STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	344003	A. BUILDING _____ B. WING _____	C 05/09/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHERRY HOSPITAL	201 STEVENS MILL ROAD GOLDSBORO, NC 27530

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 038	482.13 PATIENTS' RIGHTS A hospital must protect and promote the rights of each patient. This CONDITION is not met as evidenced by: Based on record review and staff interviews, the hospital failed to protect and promote the patient's right to be free from neglect and failed to use safe restraining technique. Specifically, staff failed to monitor the patient in accordance with the hospital's special precautions policy and failed to use safe restraining technique. Cross refer: Tag A-0058 Privacy and Safety, CFR 482.13(c)(3). The hospital failed to prevent neglect for 1 of 1 patient sampled (patient #1) on close observation. Cross refer: Tag A-0088 Seclusion and Restraint for Behavior Management, CFR 482.13(f)(3)(v). The hospital failed to use safe and appropriate restraint techniques for 1 of 1 patient sampled (patient #1).	A 038		7/1/07
A 058	482.13(c)(3) FREE FROM ABUSE & HARASSMENT The patient has the right to be free from all forms of abuse or harassment. This STANDARD is not met as evidenced by: Based on record review and staff interviews, the hospital failed to prevent neglect for 1 of 1 patient sampled (patient #1) on close observation. Specifically, patient #1 fell from a wheelchair while left unattended.	A 058		7/1/07

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	344003	A. BUILDING _____ B. WING _____	C 05/09/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A 058	Continued From page 1 Findings include: Medical record review conducted on 5-8-07 revealed patient #1, a 48-year-old male, was admitted to U2/3 West on 3-25-07 with the diagnoses of Bipolar Disorder, Most Recent Episode Manic, and Alcohol and Cannabis Abuse. Patient #1 was discharged on 4-12-07. Further review of the medical record revealed a physician's order (verbal order), dated 3-26-07 at 9:00am, which indicated patient #1 was placed on CO (close observation) 1:1 precautions. On 5-9-07 the hospital's policy entitled "Precautions, Special" was reviewed. According to the policy, "CO is the most restrictive level of observation. Designated staff members on each shift shall be responsible for keeping the patient within arms length AT ALL TIMES". Further review of patient #1's medical record revealed a physician assistant (PA) progress note, dated 4-3-07 at 4:00pm. The note indicated patient #1 had fallen from his wheelchair. The PA documented "plan: ...Case discussed with staff nurse for the CO (close observation) to be with pt (patient) all the time". Continued review of patient #1's medical record revealed a late entry nursing progress note, dated 4-6-07 at 5:15pm. The nurse documented "Late entry for 4-3-07: At approximately 3:30pm, HCT (Health Care Technician) reported that (name of patient #1) had fallen out of his wheelchair. PA notified...No injuries noted". On 5-9-07 the hospital's investigation report (Case # 1839), completed by a patient advocate,	A 058		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	344003	A. BUILDING _____ B. WING _____	C 05/09/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A 058	Continued From page 2	A 058		

was reviewed. According to the report, the incident under investigation was as follows: Staff members reported a Health Care Technician (Staff #1) left patient #1 "unattended" and did not notify appropriate staff. Patient #1 was on close observation 1:1 and fell from the wheelchair while unattended. According to the investigation report, the incident occurred on 4-3-07.

On 5-9-07 the U2/3 West Assignment Sheet for 4-3-07 was reviewed. According to the document, staff #1 was assigned CO (close observation) for patient #1 for 1st shift (7am-3:30pm).

Further review of the investigation report revealed documentation of an interview conducted with staff #1. The interview with staff #1 was conducted by a patient advocate and nurse manager. According to the interview, at the end of the shift (3:30pm) on 4-3-07 , staff #1 reported he needed to leave and go pay a light bill. In the interview with the advocate, staff #1 reported he notified another Health Care Technician (staff #2) he was leaving and staff #2 agreed to watch patient #1. Further review of the interview revealed "I (staff #1) was pretty secure that he (staff #2) was going to take my spot..."

On 5-9-07 an interview was conducted with staff #1. Staff #1 confirmed he was assigned CO 1:1 with patient #1 on 1st shift on 4-3-07. Staff #1 reported it was during shift change and "I had a very important place to go". Staff #1 revealed he asked a 2nd shift staff (staff #1 was unable to recall this staff's name) to watch patient #1 and "gave him the board" (to document patient #1's CO). Staff #1 reported he clocked out and left and did not know patient #1 had fallen until he

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	344003	A. BUILDING _____ B. WING _____	C 05/09/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A 058	Continued From page 3	A 058		

came back to work 2 days later. Staff #1 reported he worked on another unit (U2/3 East) during the investigation. Staff #1 reported he was currently back on U2/3 West. According to staff #1, he currently could not be assigned CO 1:1 with patient #1 (patient #1 had been re-admitted), but could be assigned CO 1:1 with other patients.

Further review of the advocate's investigation report revealed documentation of an interview conducted with staff #2 (2nd shift Health Care Technician). The interview was conducted by a patient advocate and nurse supervisor. The interview revealed staff #2 was doing vital signs and heard patient #1 fall out of the wheelchair. Staff #2 reported staff #1 was previously sitting CO 1:1 with patient #1 and "...he (staff #1) brought me the clipboard and said he had to leave". Documentation revealed staff #2 did not know if staff #1 intended for him (staff #2) to take over his CO 1:1 with patient #1. Staff #2 stated, "To me he (staff #1) wasn't properly relieved". Further review of the interview revealed the 2nd shift assignment had not been made out yet: "Actually we didn't get no assignments because there wasn't no nurse up there at the time. No we didn't actually get report or anything. Dayshift didn't tell us anything. Basically as soon as they saw us they left. We didn't get report or any assignment".

On 5-9-07 an interview was conducted with staff #2. Staff #2 reported he was sitting at the vital signs table and heard patient #1 fall. Staff #2 revealed it was shift change and no one (from 2nd shift) had been assigned to patient #1 at that time. Staff #2 reported the 1st shift staff (staff #1) who had been working with patient #1 said he had to leave. According to staff #2, staff #1 "said he

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	344003	A. BUILDING _____ B. WING _____	C 05/09/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHERRY HOSPITAL	201 STEVENS MILL ROAD GOLDSBORO, NC 27530

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A 058	Continued From page 4	A 058		

had to go and dropped the clipboard off". Staff #2 reported they (2nd shift) had not been given report so they just started working.

Further review of the investigation report revealed documentation of an interview conducted with staff #3 (2nd shift Health Care Technician). The interview with staff #3 was conducted by a patient advocate. The interview revealed staff #3 assisted patient #1 back to the chair after his fall. Staff #3 stated he did not know who was assigned to patient #1. "I was just coming through the dayroom making my rounds".

On 5-9-07 an interview was conducted with staff #3. Staff #3 reported he came in that day (for 2nd shift) and things were "a little unorganized". Staff #3 reported the assignment sheet had not been made out yet and he just "went to work". Staff #3 started a head count on all the patients. According to staff #3, staff #2 said patient #1 had fallen. Staff #3 ran over to patient #1 and asked if he was OK. According to staff #3, patient #1 was crawling and staff #3 helped him back to his wheelchair. Staff #3 revealed at that time he did not know who was CO 1:1 with patient #1. Staff #3 reported he now was aware of the 1st shift staff (staff #1) that had been assigned to patient #1.

On 5-9-07 an interview was conducted with staff #4, a Registered Nurse. Staff #4 reported working from 7am-7pm on the day patient #1 fell (4-3-07). Staff #4 reported hearing someone call for a nurse. Interview revealed staff #4 and another nurse went to see what happened and a Health Care Technician said patient #1 had fallen. According to staff #4, patient #1 had no injuries and patient #1 said he was not hurt. Staff #4

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	344003	A. BUILDING _____ B. WING _____	C 05/09/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHERRY HOSPITAL	201 STEVENS MILL ROAD GOLDSBORO, NC 27530

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A 058	Continued From page 5 notified the PA (physician assistant). Further review of the investigation report revealed a section which outlined the conclusions of the investigation regarding patient #1. The document indicated the investigation was conducted secondary to reports that staff #1 left patient #1 (who was on CO 1:1) at the end of the shift without proper relief. Patient #1 was unattended and fell while trying to get out of his wheelchair. The document stated there was "conclusive evidence" that staff #1 left his assignment before being relieved and violated the hospital's policy regarding close observation. The report further indicated staff #2 and #3 did not "provide temporary supervision" to patient #1 until the issue could be addressed/resolved. According to the report, there was also "concerns" about the assignment sheet not being complete when 2nd shift arrived and Health Care Technicians beginning the shift without direction from licensed staff. Further review of the report revealed "Investigation Team Recommendations", which outlined action to be taken as a result of the investigation regarding the incident with patient #1. On 5-9-07 an interview was conducted with the Director of Nursing (DON). The DON discussed the process for disciplinary action. According to the DON, staff #1 would receive formal disciplinary action to include: the specific infraction (including which policies were violated), expectations (what should be done to improve), time frame for improvement, and what will occur if the employee fails to make improvements. According to the DON, the document must be reviewed by the Human Resources Specialist, and the DON and assistant DON must also sign	A 058		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	344003	A. BUILDING _____ B. WING _____	C 05/09/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHERRY HOSPITAL	201 STEVENS MILL ROAD GOLDSBORO, NC 27530

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A 058	Continued From page 6 off on it. The DON reported then the disciplinary action will be presented to the employee. As of the date of the survey (May 8-9, 2007), staff #1 had not received formal disciplinary action for the incident that occurred on 4-3-07. Interview with staff #1 on 5-9-07 revealed he had been asked that morning (5-9-07) to review a policy regarding close observation. Further interview with the DON revealed staff #2 and #3 were to receive supervisory conferences. According to the DON, supervisory conferences were not considered formal disciplinary action. As of the date of the survey (May 8-9, 2007) supervisory conferences with staff #2 and #3 had not yet occurred. The DON indicated the nurse manager was in the process of working on completing the actions to be taken as a result of the investigation regarding patient #1.	A 058		
A 071	482.13(e)(3)(v) SAFE RESTRAINING TECHNIQUES The use of a restraint must be in accordance with safe and appropriate restraining techniques. This STANDARD is not met as evidenced by: Based on record reviews, staff interviews, facility documentation, and review of policy and procedures, the hospital failed to use safe and appropriate restraint techniques for 1 of 1 patient sampled (patient #1). Findings include: Medical record review conducted on 5-8-07 revealed patient #1, a 48-year-old male, who was admitted to U2/3 West on 3-25-07 with the	A 071		7/1/07

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	344003	A. BUILDING _____ B. WING _____	C 05/09/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A 071	Continued From page 7	A 071		

diagnoses of Bipolar Disorder- Most Recent Episode Manic and Alcohol and Cannabis Abuse. Patient #1 was discharged on 4-12-07.

Further review of medical record revealed documents completed upon the admission of patient #1. "Healthcare Checklist" dated 3-25-07 at 6:30pm indicated no injuries to his legs or head. The document entitled "Learning Assessment" noted "ambulatory with normal gait" during the admission assessment. On the "Physical Assessment" form dated 3-25-07 at 8:45 am, patient #1 had no swollen joints and the pain screen was negative. Review of admission documentation for patient #1 revealed no current injuries or reports of pain or discomfort.

Per review of "Restrictive Intervention Progress Note", patient #1 was restrained on 3-26-07. Prior to the use of restrictive intervention, patient #1 was "given Seroquel 50 mg @ 12:10 am for mood lability". The note further read "Ativan 2 mg given PO (by mouth) at 1:30 am for anxiety and mood lability." According to the note, patient #1 was unable to be redirected and he attempted to hit staff in the face, but struck staff's shoulder instead. According to the nursing assessment on the restrictive intervention note completed on 3-26-07 at 6 am, the nurse documented "during NCI hold patient hit head on door jam". On the same assessment during the 30-minute post intervention monitoring section, the nurse noted "complaining of right knee discomfort and head soreness. Right knee with redness. 2 1/2 inch laceration on head-sutures".

Progress notes were reviewed on 5-8-07. Note dated 3-26-07 at 7:26 am by the physician ' s assistant read " patient complained of laceration

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	344003	A. BUILDING _____ B. WING _____	C 05/09/2007

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CHERRY HOSPITAL	201 STEVENS MILL ROAD GOLDSBORO, NC 27530

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A 071	Continued From page 8	A 071		

to top of head after altercation " . The physician ' s assistant also noted " 4-5 cm laceration on top of head with mild bleeding " . Note dated 3-26-07 at 8:15 am by the physician 's assistant documented the suturing of the laceration to the head of patient #1. The progress notes documented no prior injuries or complaints of pain and discomfort.

Physician orders were reviewed for patient #1 on 5-8-07. Entry on 3-26-07 at 7:20 am revealed an order for Tylenol 650 mg p.o q. (every) 6 hours prn (as needed) for pain; Ace bandage for right knee; and Keflex 500 mg 1 pill po qid (4 times per day) for laceration prophylaxis " .

Review of internal investigation completed by the patient advocate revealed the investigation began on 3-30-07. The investigation consisted of multiple interviews with all the staff working on U2/3 West on the night of the incident. Patient #1 was interviewed, and but it was documented he was very confused. Patient #1 could not provide an account of how he acquired the laceration to his head or how his right knee became swollen and sore. The alleged perpetrator provided an account, which involved his properly restraining patient #1. Per report of perpetrator, patient #1 was not restrained on the floor. Patient #1 sat down on the floor after the 1-man hold was initiated. Per alleged perpetrator 's report, patient #1 was held for only 1 minute. Report from the Health Care Technician (HCT) in charge of third shift provided a different account of how patient #1 became injured. The charge HCT reported patient #1 was restrained via a bear hug by the alleged perpetrator. During the hold, the alleged perpetrator and patient #1 lost their balance and fell backwards. On the way down, patient #1 hit

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	344003	A. BUILDING _____ B. WING _____	C 05/09/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHERRY HOSPITAL	201 STEVENS MILL ROAD GOLDSBORO, NC 27530

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 071	Continued From page 9	A 071		

his head and they both fell on the floor.

The Director of Nursing Services was interviewed on 5-8-07. The director reported the alleged perpetrator has been on leave with pay while the investigation was completed. To date, he had not returned to work. The director also outlined the actions taken against the charge HCT for providing misleading information and the actions against the nurse on duty for not following up to determine the cause of the injury for patient #1. Further interview with the DON revealed both the nurse and the charge HCT were to receive supervisory conferences. According to the DON, supervisory conferences were not considered formal disciplinary action. As of the date of the survey (May 8-9, 2007) supervisory conferences with the charge HCT and the nurse on duty had not yet occurred. The DON indicated the nurse manager was in the process of working on completing the actions to be taken as a result of the investigation regarding patient #1.

An interview was conducted with the charge HCT on 5-9-07. The HCT provided the same information documented in the internal investigation. Per interview, the alleged perpetrator restrained patient #1 with a bear hug and the pair fell backwards to the floor. Patient #1 hit his head on the way down.

An interview was conducted with the alleged perpetrator on 5-9-07. The perpetrator provided an account identical to the account in the interval investigation. The alleged perpetrator maintained he placed patient #1 in a 1-man hold for about a minute and patient #1 sat on the floor after the hold was over. He proceeded with his work duties. He heard a loud thump and turned and

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	344003	A. BUILDING _____ B. WING _____	C 05/09/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHERRY HOSPITAL	201 STEVENS MILL ROAD GOLDSBORO, NC 27530

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A 071	Continued From page 10 saw patient #1 lying on the floor. The perpetrator came to the assistance of patient #1 and helped him up. The source of the blood was discovered after patient #1 was being walked to a chair so the nurse could provide first aid. The alleged perpetrator maintained during the interview that he did nothing wrong, and his restraint was initiated properly. The facility maintains policy and procedures on the use of restrictive interventions. Per policy, " Care shall be taken to minimize physical and mental discomfort in the use of restrictive interventions. In areas where restrictive interventions are used, provisions shall be made to ensure humane, secure, and safe conditions ".	A 071		
A 204	482.23(b)(3) RN SUPERVISION OF NURSING CARE A registered nurse must supervise and evaluate the nursing care for each patient. This STANDARD is not met as evidenced by: Based on record review and staff interviews, the hospital failed to prevent neglect for 1 of 1 patient sampled (patient #1) on close observation. Specifically, patient #1 fell from a wheelchair while left unattended. Findings include: Medical record review conducted on 5-8-07 revealed patient #1, a 48-year-old male, was admitted to U2/3 West on 3-25-07 with the diagnoses of Bipolar Disorder, Most Recent Episode Manic, and Alcohol and Cannabis Abuse. Patient #1 was discharged on 4-12-07.	A 204		7/1/07

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	344003	A. BUILDING _____ B. WING _____	C 05/09/2007

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A 204	Continued From page 11 Further review of the medical record revealed a physician's order (verbal order), dated 3-26-07 at 9:00am, which indicated patient #1 was placed on CO (close observation) 1:1 precautions. On 5-9-07 the hospital's policy entitled "Precautions, Special" was reviewed. According to the policy, "CO is the most restrictive level of observation. Designated staff members on each shift shall be responsible for keeping the patient within arms length AT ALL TIMES". Further review of patient #1's medical record revealed a physician assistant (PA) progress note, dated 4-3-07 at 4:00pm. The note indicated patient #1 had fallen from his wheelchair. The PA documented "plan: ...Case discussed with staff nurse for the CO (close observation) to be with pt (patient) all the time". Continued review of patient #1's medical record revealed a late entry nursing progress note, dated 4-6-07 at 5:15pm. The nurse documented "Late entry for 4-3-07: At approximately 3:30pm, HCT (Health Care Technician) reported that (name of patient #1) had fallen out of his wheelchair. PA notified...No injuries noted". On 5-9-07 the hospital's investigation report (Case # 1839), completed by a patient advocate, was reviewed. According to the report, the incident under investigation was as follows: Staff members reported a Health Care Technician (Staff #1) left patient #1 "unattended" and did not notify appropriate staff. Patient #1 was on close observation 1:1 and fell from the wheelchair while unattended. According to the investigation report, the incident occurred on 4-3-07.	A 204		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	344003	A. BUILDING _____ B. WING _____	C 05/09/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHERRY HOSPITAL	201 STEVENS MILL ROAD GOLDSBORO, NC 27530

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A 204	Continued From page 12	A 204		

On 5-9-07 the U2/3 West Assignment Sheet for 4-3-07 was reviewed. According to the document, staff #1 was assigned CO (close observation) for patient #1 for 1st shift (7am-3:30pm).

Further review of the investigation report revealed documentation of an interview conducted with staff #1. The interview with staff #1 was conducted by a patient advocate and nurse manager. According to the interview, at the end of the shift (3:30pm) on 4-3-07 , staff #1 reported he needed to leave and go pay a light bill. In the interview with the advocate, staff #1 reported he notified another Health Care Technician (staff #2) he was leaving and staff #2 agreed to watch patient #1. Further review of the interview revealed "I (staff #1) was pretty secure that he (staff #2) was going to take my spot..."

On 5-9-07 an interview was conducted with staff #1. Staff #1 confirmed he was assigned CO 1:1 with patient #1 on 1st shift on 4-3-07. Staff #1 reported it was during shift change and "I had a very important place to go". Staff #1 revealed he asked a 2nd shift staff (staff #1 was unable to recall this staff's name) to watch patient #1 and "gave him the board" (to document patient #1's CO). Staff #1 reported he clocked out and left and did not know patient #1 had fallen until he came back to work 2 days later. Staff #1 reported he worked on another unit (U2/3 East) during the investigation. Staff #1 reported he was currently back on U2/3 West. According to staff #1, he currently could not be assigned CO 1:1 with patient #1 (patient #1 had been re-admitted), but could be assigned CO 1:1 with other patients.

Further review of the advocate's investigation

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	344003	A. BUILDING _____ B. WING _____	C 05/09/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHERRY HOSPITAL	201 STEVENS MILL ROAD GOLDSBORO, NC 27530

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 204	Continued From page 13	A 204		

report revealed documentation of an interview conducted with staff #2 (2nd shift Health Care Technician). The interview was conducted by a patient advocate and nurse supervisor. The interview revealed staff #2 was doing vital signs and heard patient #1 fall out of the wheelchair. Staff #2 reported staff #1 was previously sitting CO 1:1 with patient #1 and "...he (staff #1) brought me the clipboard and said he had to leave". Documentation revealed staff #2 did not know if staff #1 intended for him (staff #2) to take over his CO 1:1 with patient #1. Staff #2 stated, "To me he (staff #1) wasn't properly relieved". Further review of the interview revealed the 2nd shift assignment had not been made out yet: "Actually we didn't get no assignments because there wasn't no nurse up there at the time. No we didn't actually get report or anything. Dayshift didn't tell us anything. Basically as soon as they saw us they left. We didn't get report or any assignment".

On 5-9-07 an interview was conducted with staff #2. Staff #2 reported he was sitting at the vital signs table and heard patient #1 fall. Staff #2 revealed it was shift change and no one (from 2nd shift) had been assigned to patient #1 at that time. Staff #2 reported the 1st shift staff (staff #1) who had been working with patient #1 said he had to leave. According to staff #2, staff #1 "said he had to go and dropped the clipboard off". Staff #2 reported they (2nd shift) had not been given report so they just started working.

Further review of the investigation report revealed documentation of an interview conducted with staff #3 (2nd shift Health Care Technician). The interview with staff #3 was conducted by a patient advocate. The interview revealed staff #3

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A 204	Continued From page 14	A 204		

assisted patient #1 back to the chair after his fall. Staff #3 stated he did not know who was assigned to patient #1. "I was just coming through the dayroom making my rounds".

On 5-9-07 an interview was conducted with staff #3. Staff #3 reported he came in that day (for 2nd shift) and things were "a little unorganized". Staff #3 reported the assignment sheet had not been made out yet and he just "went to work". Staff #3 started a head count on all the patients. According to staff #3, staff #2 said patient #1 had fallen. Staff #3 ran over to patient #1 and asked if he was OK. According to staff #3, patient #1 was crawling and staff #3 helped him back to his wheelchair. Staff #3 revealed at that time he did not know who was CO 1:1 with patient #1. Staff #3 reported he now was aware of the 1st shift staff (staff #1) that had been assigned to patient #1.

On 5-9-07 an interview was conducted with staff #4, a Registered Nurse. Staff #4 reported working from 7am-7pm on the day patient #1 fell (4-3-07). Staff #4 reported hearing someone call for a nurse. Interview revealed staff #4 and another nurse went to see what happened and a Health Care Technician said patient #1 had fallen. According to staff #4, patient #1 had no injuries and patient #1 said he was not hurt. Staff #4 notified the PA (physician assistant).

Further review of the investigation report revealed a section which outlined the conclusions of the investigation regarding patient #1. The document indicated the investigation was conducted secondary to reports that staff #1 left patient #1 (who was on CO 1:1) at the end of the shift without proper relief. Patient #1 was unattended

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A 204	Continued From page 15	A 204		

and fell while trying to get out of his wheelchair. The document stated there was "conclusive evidence" that staff #1 left his assignment before being relieved and violated the hospital's policy regarding close observation. The report further indicated staff #2 and #3 did not "provide temporary supervision" to patient #1 until the issue could be addressed/resolved. According to the report, there was also "concerns" about the assignment sheet not being complete when 2nd shift arrived and Health Care Technicians beginning the shift without direction from licensed staff.

Further review of the report revealed "Investigation Team Recommendations", which outlined action to be taken as a result of the investigation regarding the incident with patient #1. On 5-9-07 an interview was conducted with the Director of Nursing (DON). The DON discussed the process for disciplinary action. According to the DON, staff #1 would receive formal disciplinary action to include: the specific infraction (including which policies were violated), expectations (what should be done to improve), time frame for improvement, and what will occur if the employee fails to make improvements. According to the DON, the document must be reviewed by the Human Resources Specialist, and the DON and assistant DON must also sign off on it. The DON reported then the disciplinary action will be presented to the employee. As of the date of the survey (May 8-9, 2007), staff #1 had not received formal disciplinary action for the incident that occurred on 4-3-07.

Interview with staff #1 on 5-9-07 revealed he had been asked that morning (5-9-07) to review a policy regarding close observation.

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A 204	Continued From page 16 Further interview with the DON revealed staff #2 and #3 were to receive supervisory conferences. According to the DON, supervisory conferences were not considered formal disciplinary action. As of the date of the survey (May 8-9, 2007) supervisory conferences with staff #2 and #3 had not yet occurred. The DON indicated the nurse manager was in the process of working on completing the actions to be taken as a result of the investigation regarding patient #1.	A 204		